

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=62-033201

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 317 Primary Registration District No. 542 Registrar's No. 2210

FILED AUG 20 1962

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY - - -	
b. CITY (If outside corporate limits, give TOWNSHIP only) Ferguson, Missouri		c. CITY OR TOWN St. Louis	
Length of stay in 1b 3 years		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Oak Knoll Nursing Home		d. STREET ADDRESS (If outside, give location) 3608 Castleman	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED A/K/A First Alta Middle Harriet Last Lane			4. DATE OF DEATH Month July Day 29 Year 1962		
5. SEX F			6. COLOR OR RACE W		
7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>			8. DATE OF BIRTH 4-29-1880		
9. AGE (last birthday) 82			10. IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Secretary (Ret.)			10b. KIND OF BUSINESS OR INDUSTRY Medical		
11. BIRTHPLACE (City and state or country) Evansville, Ind.			12. CITIZEN OF WHAT COUNTRY U.S.A.		

13a. FATHER'S NAME George Lane		13b. MOTHER'S MAIDEN NAME Sarah Woods		14. NAME OF HUSBAND OR WIFE never married	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		17. INFORMANT Mrs. LeRoy, Busch		Address 3815 Bowen	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction		INTERVAL BETWEEN ONSET AND DEATH 1/2 hr.
DUE TO (b) Generalized arteriosclerosis		
DUE TO (c)		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
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20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY	STATE
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21. I attended the deceased from July 15, 1962 to July 29, 1962 and last saw her alive on July 28, 1962
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Death occurred at 2:15 pm on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Charles Kilo, M.D.	(Degree or title)	22b. ADDRESS 5755 CATES AVE ST. LOUIS 12, MO	22c. DATE SIGNED July 30, 1962
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 7-31-62	23c. NAME OF CEMETERY OR CREMATORY Park Lawn Cemetery	23d. LOCATION (City, town, or county) St. Louis County, Missouri
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24. FUNERAL DIRECTOR HOFFMEISTER COLONIAL MORTUARY	ADDRESS 6464 Chippewa	25. DATE RECD. BY LOCAL REG. 7-30-62	26. REGISTRAR'S SIGNATURE John. Murphy M.D.
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(Licensed Embalmer's Statement on Reverse Side)

VS 300
Rev. 4/59

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK
OR
TYPEWRITER RIBBON

Dr. Charles Kilo
St. Lukes Hospital
5535 Delmar
FO. 7-1680

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by _____ Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed

John L. Denney

Licensed Embalmer No.

41990

P. O. Address

St. Louis, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.